"Provider Orientation to Medicaid/Medical Assistance Program Integrity Audits & Reviews"

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This document provides an orientation and overview of the provider audit and post-payment review processes followed by the Office of Program Integrity (OPI). OPI conducts provider audits and reviews under the direction of the Medicaid Purchasing Administration (MPA) and the Department of Social and Health Services (DSHS) for Washington Medicaid and State-only Medical Assistance programs.

What is the purpose of OPI's program integrity audits and reviews?

The Office of Program Integrity maintains a strong commitment to identify improper payments, and potential fraud, waste and abuse to ensure that State and Federal tax dollars are spent appropriately. This commitment is driven by a firm intent to assure that the right provider is receiving the right payment for the right services at the right time.

OPI strives for collaboration and partnership with its internal and external stakeholders to improve accountability for how health care funds are spent. OPI must also be in compliance with Federal Medicaid audit and program integrity initiatives. Coordination of Medicaid fraud, waste and abuse activities requires partnership with every administration entrusted with taxpayer dollars. Program integrity is everybody's business.

When discussing fraud, waste and abuse in the Medicaid program, it is important to remember that Medicaid is jointly operated and funded by the Federal government and from the State's general funds.

The Office of Program Integrity also refers any quality of care concerns it discovers during the course of the audit/review process to the appropriate state authorities.

What kinds of audits and reviews does OPI conduct?

OPI conducts several types of audits/reviews which include, but are not limited to:

Desk Audit-Review – An audit or review conducted at the Office of Program Integrity. A notification letter with request for records is sent to the provider and generally requires the provider to submit copies of the requested records. Audit staff may conduct provider and/or provider personnel interviews by phone. Some examples of desk audits and reviews are clinical reviews, pharmacy third party liability (TPL) audits, hospital outpatient claims audits, and hospital credit balance reviews.

Onsite/Field Audit – An audit conducted at a provider's place of business. A letter of "intent to audit" or a notification letter is sent by the OPI auditor to the provider prior to the onsite visit stating the date and time of the audit. Audit staff will make copies of the provider's

records when onsite, review provider's billing protocols, and interview the provider and/or provider personnel.

Surveillance and Utilization Review Section (SURS) Provider Review - A review of a provider's billed services based on either a complaint received by the Surveillance and Utilization Review Section or anomalies in services identified through utilization reports and/or data mining.

Data mining/Algorithm - A review applying rules-based filters (called algorithms) to claims payment data to identify overpayments within the Washington Medicaid program.

What Federal audits or reviews can a provider expect?

There are several Federal government audit/review and program integrity initiatives administered by the Centers for Medicare and Medicaid Services (CMS) or CMS contractors, and may include the Office of Inspector General (OIG). Washington's Medicaid providers may receive notification letters and record requests from CMS contractors advising them they have been selected for an audit or review. Below are websites with information about these audits and how providers are notified about the Federal audit and review process:

- CMS **Medicaid Integrity Program (MIP)** audits – For information about the MIP, including what to expect during a MIP audit, and an outline of the audit process itself, please visit the following websites:

  http://www.cms.hhs.gov/MedicaidIntegrityProgram.

  http://www.cms.gov/ProviderAudits/CMS Medicaid Integrity Program

- CMS **Payment Error Rate Measurement (PERM)** reviews – PERM uses a 17-state rotational approach to measure improper payments in Medicaid and Children's Health Insurance Program (CHIP) for the 50 states and the District of Columbia over a three-year period. As a result, each state is measured once every three years. The state will notify providers who are selected to be part of the PERM review. Providers will be contacted by the PERM contractor with a request for records. For further information on PERM see the following websites:

  http://hrsa.dshs.wa.gov/News/PERM.htm

  http://www.cms.gov/perm/

  www.paymentaccuracy.gov

- Health & Human Services (HHS) Office of Inspector General (OIG) audits – General OIG audit information can be found at: http://oig.hhs.gov/

What is OPI's authority to audit, investigate and review Medicaid/Medical Assistance providers?

Federal and State laws mandate identifying and recovering improper payments and other program integrity activities through audits, investigations, and reviews.

- Federal Executive Order No. 13520 (11/20/09).
- Improper Payments Information Act of 2002.
- Presidential Memorandum Regarding Finding and Recapturing Improper Payments (3/10/2010).
- Links to other Federal mandates and requirements:
  http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

  42 CFR 431.10 State agency designee to administer Medicaid program.
  42 CFR 447.202 Payment for services – Audits.
  42 CFR 455 Requirements for State fraud detection.
  42 CFR 438 Managed Care.
  42 CFR 465 Utilization Control.
  42 CFR 1001 Program Integrity.

- Links to Washington State audit/review mandates and requirements:
  http://www.leg.wa.gov/CodeReviser/Pages/default.aspx

  RCW 74.09.200 Department's authority to conduct audits and investigations.
  WAC 388-502A Provider audits and appeals process.
  WAC 388-502-0230 Provider reviews and appeals.

How will providers know if they are being audited or reviewed by the OPI?

- For provider audits OPI sends an intent to audit/notification letter to providers announcing the audit and the time frame of the audit; or
- For clinical reviews OPI sends a record request letter announcing a clinical or post-payment review; or
- OPI sends an overpayment notice or letter when a PRP algorithm or SURS review has identified overpayments.
- As authorized by WAC 388-502A-0600, unannounced visits may occur.
- For PERM reviews & MIP audits see the Federal audit section and links on page 2 of this guide for more details.

What types of records will OPI request during an audit or review?

Providers must retain documentation that supports the services billed to the MPA. OPI may request the following types of information and records; please note that **this is not an all-inclusive listing**:

- Prescription records
- Office visit/hospital visit notes

- Patient care plans
- Diagnostic test results (e.g. lab reports, radiology/nuclear medicine reports, etc.)
- Dental x-ray films
- Physician/practitioner orders
- Surgical, recovery & anesthesia records
- Durable & non-durable medical equipment/product delivery documents
- Treatment records
- Transfer records/referral documents
- Medication administration records/sheets
- Financial reports/accounting/billing records, charge masters, service level descriptions
- Third party insurance documents
- Credit balance reports
- Appointment books/patient sign-in sheets
- Ownership agreement/business license and professional staff licenses/certificates
- Office/facility policies/employment records
- Complete hospital medical records

How long must a provider keep records for audit or review purposes?

Providers must maintain appropriate documentation in the client's medical or health care service records for **6 years** to verify the level, type, and extent of services provided. Pursuant to WAC 388-502-0020 providers must:

(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client;

(b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains; and

(c) Make charts and records available to DSHS, its contractors, and the U.S. Department of Health and Human Services upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation. Refer to WAC 388-502-0020 for additional provider requirements. Refer to section 1902 (a) (27) of the Social Security Act for Federal record keeping requirements.

Per the provider's Core Provider Agreement, the provider shall retain all original records and documents that support services billed and paid by the MPA.

Please note: If a provider is being audited all records need to be retained until the audit is completed and all issues are resolved, even if the period of retention extends beyond the required 6 year period.

Will original records be removed from a provider's office/facility?

No original provider records and/or information will be removed by the auditors when conducting an onsite audit. Audit staff will either make copies or request copies be made of original provider records and/or information.

Are providers reimbursed for costs incurred during an audit?

No, WAC 388-502A-0800 (6) states "The department does not reimburse a provider's administrative fees, such as copying fees, for records requested during an audit."

How does a provider prepare for an onsite audit?

When possible, OPI works with the provider to minimize inconvenience and disruption of health care delivery during the audit. Providers can prepare by doing the following:

- Provide a work space or room, with table and chairs and adequate electrical outlets for audit equipment.
- Have key office staff available during the audit for the audit team to interview.
- If medical records are requested in advance, please have records in alphabetical order placed in the designated workspace for the auditors.
- Have copies of current business license(s) and professional healthcare licenses of all pertinent staff available for the auditors.

What happens during an onsite audit?

Entrance Conference: The audit team conducts an **Entrance Conference** on the first day of the onsite audit. They will introduce themselves and provide general information about the audit process, including an information packet containing a list of pertinent MPA contacts, billing instructions, RCW's and WACs that pertain to the audit. During the entrance conference, the provider should be prepared to introduce key office personnel and provide a tour of their facility.

Onsite Work: The audit team makes copies of necessary documents/information, conducts key staff interviews, and reviews office processes.

Exit Conference: The **Exit Conference** typically takes place on the last day of the audit. In limited circumstances an Exit Conference may be scheduled several weeks after the onsite audit. The audit lead worker conducts the Exit Conference with the provider and their key staff. It allows the audit team to ask any further clarifying questions and to discuss what the next steps in the audit process are with the provider.

Post Onsite Visit: Upon completion of the onsite visit the provider can expect the review of medical and financial records to take 2-6 months depending on the nature and size of the review/audit. Any records still missing will be requested in a post-audit follow-up letter. The provider is required to mail any missing records to OPI within 30 days of that letter.

How is a provider notified of audit/review/algorithm results?

Draft Audit Report/Preliminary Clinical Review Notice: Once the review of provider information and records is completed, the provider is mailed a draft audit report/preliminary clinical review notice. The provider is given 30 days to respond to the draft audit report/preliminary clinical review notice.

Final Audit Report/Clinical Overpayment Notice: Once the draft audit/preliminary clinical review notice response time is expired or dispute process is completed, the final audit report/clinical overpayment notice is sent to the provider. This audit report/notice contains the final overpayment amount and directives.

PRP/SURS overpayment notice: When a SURS review or PRP algorithm is completed, an overpayment notice may be issued. This notice contains the final overpayment amount and may contain directives.

What dispute or appeal rights does a provider have in regards to the audit/review or overpayment notice findings?

Draft audits/preliminary clinical review notices: (WAC 388-502A-1100)

- Providers have **30 days** from receipt of the draft audit report or preliminary clinical review notice to dispute the draft audit or preliminary clinical review findings. Providers must submit the dispute in writing, include what findings they are contesting, and supply documentation to support their position.

Final audits/clinical overpayment notices: (WAC 388-502A-1200)(WAC 388-502-0230)

- Providers have **28 days** from receipt of the final audit report/clinical review overpayment notice to request an administrative hearing/appeal of the final audit findings. Providers must submit the request in writing, including the basis for contesting the audit, and including a copy of the final audit report. The written request must be served in a manner which provides proof of receipt and must be sent to:

  The Office of Financial Recovery
  P.O. Box 9501
  Olympia, WA 98507-5501

PRP/SURS overpayment notice:

- This notice provides information for both informal and formal dispute resolution processes. These processes must be requested no later than **28 days** after the provider receives the overpayment notice. The informal process allows the provider to submit documentation to dispute the overpayment finding. If the OPI agrees with the documentation, the overpayment may be revised. Providers may access **both** the informal and formal dispute resolution processes simultaneously, or choose one or the other. Accessing the informal process does not extend the 28-day timeframe for requesting a formal dispute resolution hearing.

How long does an audit or review take?

Audit and Review Notification to Audit Timeline:

Required notice of intent to audit to providers – WAC 388-502A-0600

- Non- hospital providers receive **ten** business days notice of intent to audit.
- Hospitals receive **thirty** calendar days notice of intent to audit.
- There are exceptions to notice requirement for suspected fraud or abusive practices, or if patient health and safety concerns exist.

Draft Report/Preliminary Clinical Review Notice Timeline:

- The average time from the onsite visit or formal request for records to issuance of the draft audit report or preliminary clinical review notice is six months

Informal Dispute Timeline:

- If a provider disputes any draft or preliminary clinical review findings, they have **thirty** calendar days from the date the draft audit report or preliminary clinical review notice is received to notify OPI of what they are disputing. (WAC 388-502A-1100)
- The dispute process on average takes **three** months to complete.

Final Report/Clinical Overpayment Notice Timeline:

- On average, the final audit report/clinical overpayment notice is issued within **three** months following the dispute process.
- If no dispute is received, the final audit report or clinical overpayment notice on average is issued within **two** months following the draft audit report or preliminary clinical review findings notice.

Appeals Timeline:

- If a provider appeals the overpayment, they have **twenty-eight** calendar days from the receipt date of the final audit report or overpayment notice to request an adjudicative proceeding, also known as an "administrative hearing." This process follows the Administrative Procedure Act, chapter 34.05 RCW and is outlined in RCW 43.20B.670. (WAC 388-502A-1200 and WAC 388-502-0230)

What methodologies does OPI use to select services to audit/review?

Several methods are used to select services to audit. They include:

- Use of algorithms to identify billing aberrancies;
- 100% review of a provider's paid claims for a specific time period;
- Random or criteria-driven selection of specific paid procedure codes or claims for a specific time period (non-projected findings);
- Random claims/procedure selection process which uses a stratified sample of a provider's paid claims universe, including extrapolating any aberrant findings.

For more information on random sampling and extrapolation, please see OPI Sampling and Extrapolation Process. (click on link) http://hrsa.dshs.wa.gov/Audits/pdf/ExtrapProcess.pdf

Who might receive a copy of the audit/review report?

As stakeholders in the provider audit and review process, the Office of Financial Recovery, Department of Health, Attorney General's Office, and/or Medicaid Fraud Control Unit may receive copies of audit/review reports and overpayment notices. WAC 388-502A-1300 allows referral for disciplinary or criminal action if warranted.